NON-PHYSICIAN PRACTITIONER BILLING AND DOCUMENTATION GUIDANCE

OFFICE OF CORPORATE COMPLIANCE
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I. PURPOSE
This guidance provides information on the required qualifications, coverage criteria, billing and payment for Medicare Services provided by non-physician practitioners in accordance with policies and guidelines established by the Centers for Medicare and Medicaid Services (CMS).

Non-physician practitioners include Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), specifically Nurse Practitioners (NPs), Certified Nurse-Midwives (CNMs), and Clinical Nurse Specialists (CNSs).

II. QUALIFICATIONS AND COVERAGE CRITERIA OF SERVICES PROVIDED BY A NON-PHYSICIAN PRACTITIONER

A. Advance Practice Registered Nurses (APRNs)

- **Required Qualifications:** The services of APRNs may be covered by CMS under Part B if the APRN is legally authorized to perform the service in the State which they are performed and has obtained Medicare billing privileges.

- **Coverage Criteria:**
  - APRN is legally authorized and qualified to furnish the services in the State where services are performed
  - Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary
  - Services are the type considered physicians’ services if furnished by a medical doctor or a doctor of osteopathy
  - When required, services are performed in collaboration with a physician (see section below “Medicare Collaboration and Supervision Requirements”)
  - Assistant-at-surgery services furnished by a NP may be covered
  - Incident to services and supplies may be covered if requirements such as supervision and place of service are met (see section titled “Incident-to Billing” for details).

- **Medicare Collaboration and Supervision Requirements:** Medicare defines collaboration as a process in which an APRN works with one or more physicians (MD/DO) to deliver health care services with medical direction and appropriate supervision as required by the laws of the State in which the services are performed.

The Illinois Nurse Practice Act (225 ILCS 65) clarifies that a written collaborative agreement is required of all practicing APRNs until they have completed 250 hours of continuing education or training and at least 4,000 hours of clinical experience after first
attaining national certification, except for APRNs who are privileged to practice in a hospital, hospital affiliate, or ambulatory surgical treatment center.

It is not required for the collaborating physician to be present when services are furnished by APRN so long as the physician can be reached for consultation by telephone or other electronic communications. The one exception is in the case of incident-to billing where direct supervision by the billing physician is required. See the “incident-to billing” section below for more detail.

- **Payment:** When APRNs bill CMS for covered services using their National Provider Identification (NPI) number, they are paid at 80% of the lesser of the actual charge or 85% (for NPs and CNSs) and 100% (for CNMs) of the Medicare Physician Fee Schedule. There is a separate payment policy for paying NP and CNS assistant-at-surgery services.

B. Physician Assistants (PAs)

- **Required qualifications** The services of PAs may be covered by CMS under Part B if the PA is legally authorized to perform the service in the State which they are performed and has obtained Medicare billing privileges.

- **Coverage Criteria:**
  o Services are performed by a PA who meets all PA qualifications and is legally authorized and qualified to furnish the services in the State where services are performed
  o Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary
  o Services are the type considered physicians’ services if furnished by a medical doctor or a doctor of osteopathy
  o Assistant-at-surgery services furnished by a PA may be covered
  o Incident to services and supplies may be covered if requirements such as supervision and place of service are met (see section titled “Incident-to Billing” for details).

- **Medicare Collaboration and Supervision Requirements:** Services provided by a PA must be performed under the general supervision of an MD/DO. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient.

  *NOTE: For services provided by a PA beginning on January 1, 2019, CMS will permit PAs to practice in accordance with state law supervisory requirements, rather than under general physician supervision.*
The Illinois Physician Assistant Practice Act of 1987 (225 ILCS 595/7.5) clarifies that a PA who is privileged to practice in a hospital, hospital affiliate, or a licensed ambulatory surgical treatment center may provide services without a written collaborative agreement.

In all other settings, there must be a written collaborative agreement that specifies which authorized procedures require the presence of the collaborating physician as the procedures are being performed. It is not required for the collaborating physician to be present when services are furnished by the PA so long as the physician can be reached for consultation by radio, telephone or other electronic communications. The one exception is in the case of incident-to billing where direct supervision by the billing physician is required. See the “incident-to billing” section below for more detail.

- **Payment:** When a PA bills CMS for covered services using their National Provider Identification (NPI) number, they are paid at 80% of the lesser of the actual charge or 85% of the Medicare Physician Fee Schedule. There is a separate payment policy for paying for PA assistant-at-surgery services.

For more details regarding the qualifications which must be met in order for APRNs and PAs to provide and bill for covered services, see sections 180 (CNMs), 190 (PAs), 200 (NPs), and 210 (CNS') of the Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services.

### III. PLACE OF SERVICE

On a Medicare claim, the Place of Service (POS) code is used to identify the setting where the beneficiary received the face-to-face encounter with the billing provider. Below is a list of some UCMC facilities and their corresponding POS code.

- **DCAM:** POS code 22 (Outpatient Hospital-On campus)
- Inpatient units in Comer Children’s Hospital, Center for Care and Discovery, and Bernard-Mitchell Hospital: POS code 21 (Inpatient Hospital)
- Adult Trauma Center and Comer Children’s Hospital Emergency Room: POS code 23 (Emergency Room)
- Off-campus offices (i.e., Huron, South Loop): POS code 11 (Office)

Place of service is also an important consideration when determining what type of billing may be used to submit claims for NPP services. For example, services provided by an NPP in the office setting may be submitted to CMS using direct billing, split-shared billing, or incident-to billing. However, in the hospital, incident-to billing for NPP services is not allowed. See Section IV for more details about these billing options.
IV. BILLING OPTIONS

In order to bill under their own names, NPPs must have their own National Provider Identifier (NPI) number. The following types of reimbursement options are available for services provided by NPPs.

A. Direct Billing

The traditional method of provider reimbursement is direct from the payor. An enrolled/credentialed provider, such as an NPP, personally provides service to that payor's beneficiaries, independently documents the service and receives payment based on the provider fee schedule. Services performed and documented by an NPP are applicable to:

- New patient E/M visits
- Established patient E/M visits
- Consultation services
- Hospital inpatient and outpatient services
- Emergency Department services
- In-office procedures
- Other services

When Medicare billing and documentation requirements are met, services billed to Medicare under the NPP’s NPI are reimbursed at 85% of the Medicare Physician Fee Schedule Amount (MPFS). Supervision of the NPP by a physician during the delivery of the billable service is not required.

B. Incident-to Billing

Incident-to services are defined as those services that are furnished incident to physician professional services in the physician’s office (POS 11) or in a patient’s home. Medicare reimburses at 100% when an NPP provides services billed under a physician’s NPI.

Incident-to services are also relevant to services supervised by NPPs but are reimbursed at 85% of the physician fee schedule when billed under the NPP. These services are subject to the same requirements as physician-supervised services. For clarity, the rest of this section on incident-to billing will refer to “Physician services” as inclusive of NPPs.

1. Conditions of incident-to billing

   a. To qualify as “incident-to,” services must be part of the patient’s normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the patient’s course of treatment;

   b. The services must be an integral part of the patient’s treatment course, commonly rendered without charge (included in the physician’s bills), and commonly furnished in a physician’s office (not in an institutional setting).
c. During the services, the physician must provide direct supervision during the patient’s visit. The physician does not have to be physically present in the patient’s treatment room while the services are provided, but must be present in the office suite to render assistance, if necessary.

d. If an established patient presents with a new or worsening problem, incident-to does not apply.

2. **Location of service**

   Incident-to billing applies to professional services or supplies that are furnished in an Office (POS 11), and in some cases the home or private residence of a patient (POS 12).

   It does not apply to services provided in a hospital or facility (such as the DCAM, Comer, CCD, or Mitchell hospitals). This is due to the bundling provision (§1862 (a)(14) of the Social Security Act (the Act) for hospitals which provides that payment for all services are made to the hospital by a Part A Medicare Administrative Contractor (MAC) (except for certain professional services personally performed by physicians and other allied health professionals). Therefore, incident to services are not separately billable to the Part B MAC or payable under the physician fee schedule.

   For more information about incident-to billing, please consult CMS’ Medicare Matters Number: SE0441 or contact the Office of Corporate Compliance.

C. **Split-shared Billing for Evaluation and Management Services**

   In 2002, CMS issued policy instructions to allow shared evaluation and management (E/M) services between a physician and an NPP in the same group practice. A “split-shared” E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service.

   When the criteria for split-shared are met, the E/M visit may be billed under the physician’s NPI and Medicare will reimburse 100% of the MPFS amount. Alternatively, if the services are billed under the NPP’s NPI, Medicare will reimburse 85% of the MPFS amount.

   Split-shared billing is allowed under the following circumstances:

   1. The Physician and NPP must be employed by the same entity.

   *Note: Assuming the physician is employed by the Biological Sciences Division (BSD), a NPP who is employed by another company (such as the University of Chicago Medical Center), must establish a service arrangement between the UCMC and*
applicable BSD clinical department. UCMC’s cost report must also be updated accordingly under such an arrangement. In the absence of a service agreement, NPP documentation may not be used to support split-shared billing. Physicians must complete their own documentation and cannot rely on or refer to the NPP’s documentation to support the E/M service.

2. The E/M services are provided by the physician and NPP to the same patient on the same date of service. Applicable E/M services include:

- hospital admissions (99221-99223)
- subsequent visits (99231-99233)
- discharge management (99238-99239)
- observation care (99217-99220, 99234-99236)
- emergency department visits (99281-99285)
- prolonged care (99354-99357)
- hospital outpatient departments (provider-based visits) (99201-99215)

**NOTE:** Split-shared billing is not allowed for critical care services (99291-99292), consultations (99241-99255), or procedures.

3. Both the physician and NPP perform and document at least one required element of the E/M service. Additionally, a portion of the physician’s contribution must be performed face-to-face with the patient in order to bill under the physician’s NPI.

*If there is no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed by the NPP.*

4. **Documentation Requirements**

- The physician and NPP should each document their contribution to the service and sign their note.
- The NPP should not pend their note.
- For time-based split/shared encounters, the time spent by each provider must be documented and the cumulative time for both is counted for the total visit time.
- Physician’s documentation must clearly indicate that a face-to-face visit took place.
- The combined documentation from the physician and NPP should support the medical necessity of the involvement of both providers and support the level of service billed.
- Physicians should not use a Teaching Physician attestation statement to document their service.
Examples of acceptable documentation for split-shared visits:

✓ “I performed a history and physical examination of the patient and discussed his management with the NPP. I reviewed the NPP note and agree with the documented findings and plan of care.”

✓ “I saw and evaluated the patient. Agree with NPP’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

✓ *.splitsharednppvisit smart phrase “I personally performed a substantive portion of this patient encounter in conjunction with ***. The patient presents with ***. On physical examination, I personally found ***. My impression/plan is ***.”

Examples of unacceptable documentation by a physician:

X “Agree with above,” followed by legible countersignature or identity.

X “Rounded, Reviewed, Agree,” followed by legible countersignature or identity.

X “Discussed with NPP. Agree,” followed by legible countersignature or identity.

X “Seen and agree,” followed by legible countersignature or identity.

X “Patient seen and evaluated,” followed by legible countersignature or identity.

X A legible countersignature or identity alone.

D. NPPs Who Function As A Scribe

A scribe is an individual present during the physician’s performance of a clinical service who documents on behalf of the physician during the course of the service. The scribe does not act independently, but simply documents the physician’s dictation and/or activities during the visit.

NPP’s functioning in a scribe role should not allow their independent clinical judgment to influence the documentation of the service for which they are scribing. Services documented by an NPP for work that is independently performed by that NPP with the physician later making rounds is not an example of a “scribe” situation.

The physician who receives payment for the services rendered is expected to be the person delivering the services and creating the record, which is simply scribed by another person. Documentation in the medical record must support that the physician actually performed the service at the level billed and the scribe was used appropriately.

See Scribe Policy A08-45 for more detail about the appropriate use of a scribe.
REFERENCES

- Illinois Nurse Practice Act (225 ILCS 65/):
- Illinois Physician Assistant Practice Act of 1987 (225 ILCS 95/)
- Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services
- Medicare Claims Processing Manual, Chapter 12-Physicians/Nonphysician Practitioners:
  - Section 180- Nurse-Midwife (CNM) Services
  - Section 190- Physician Assistant (PA) Services
  - Section 200- Nurse Practitioner (NP) Services
  - Section 210- Clinical Nurse Specialist (CNS) Services
- National Government Services, Policy Education Topics, Split/Shared and Incident To Service
- UCMC Scribe Policy #A08-45:
  https://services.uchospitals.edu/sites/PoliciesAndProcedures/UCH%20Administrative/A08-45%20Scribe%20Policy.pdf#search=a08%2D45